LEGISLATIVE SERVICES AGENCY
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FISCAL IMPACT STATEMENT

LS 7848 **NOTE PREPARED:** Feb 2, 2003
BILL NUMBER: SB 527 **BILL AMENDED:**

SUBJECT: Long-Term Care.

FIRST AUTHOR: Sen. C. Lawson **BILL STATUS:** As Introduced
FIRST SPONSOR:

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: This bill establishes a Caretaker Support Program that is administered by the Division of Disability, Aging, and Rehabilitative Services. It sets forth eligibility requirements, caretaker support services, and a reimbursement formula. The bill adds adult foster care services to the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program. The bill also requires the Office of the Secretary of Family and Social Services to implement programs that assist disabled and elderly citizens in living with the maximum amount of freedom.

The bill also sets forth eligibility requirements for the assisted living Medicaid waiver. The bill requires providers who wish to offer services to assisted living waiver recipients to: (1) enroll with the Bureau of Aging Services; (2) ensure that the recipient receives specified rights and care; and (3) complete a service plan for the recipient that is updated as specified.

The bill also requires the Office of Medicaid Policy and Planning to apply for the following Medicaid waivers: (1) An amendment to the State Medicaid Plan to include personal care services. (2) Modification of eligibility requirements to include spousal impoverishment protection. (3) Modification of eligibility requirements to include individuals with income of not more than 300% of the federal Supplemental Security Income level. The bill also encourages the Indiana Health Facility Financing Authority to work with for-profit health facilities that are partnered with nonprofit agencies in converting licensed beds to less intensive care beds through bonds.

Effective Date: Upon passage; July 1, 2003.

Explanation of State Expenditures: *Summary:* This bill requires several significant changes in the provision of long-term care services in the state. The bill contains provisions that may result in cost savings in both the short and the long term, but could have annual additional expenditures estimated to range from $96.5 M to $215.6 M in state funds. The ultimate cost of this bill will be dependent upon legislative and

administrative actions.

This bill establishes a Caretaker Support Program to be administered by the Division of Disability, Aging, and Rehabilitative Services (DDARS). This requirement potentially has a fiscal impact associated with program administration only. No services are required to be provided, and no state funds are appropriated. *(See the background information below.)*

The bill requires the addition of adult foster care services to the list of services available under CHOICE. This provision has a fiscal impact that is associated with the administration of the new program. No services are required to be provided, and CHOICE is a capped appropriation; all services are provided within the level of the funds available. *(See the background discussion below.)*

This bill requires the Office of Medicaid Policy and Planning (OMPP) to amend the State Medicaid Plan to add personal care services as an optional benefit to which all Medicaid eligibles would be entitled statewide. A preliminary estimate of the total cost of adding this benefit in Indiana could be $57.5 M, or $21.8 M in state General Funds. Ultimately the cost of this bill would be dependent upon legislative action and administrative implementation of the benefit. (*See the background discussion below.)*

This bill requires the Office of Medicaid Policy and Planning to amend three Medicaid Waivers to include spousal impoverishment protection. This provision has a minor administrative impact that should be absorbable within the current level of resources available to DDARS. *(See the background discussion below.)*

The bill requires the Office of Medicaid Policy and Planning to amend three Medicaid waivers to increase the income eligibility standards to 300% of the Supplemental Security Income (SSI) level. A preliminary fiscal estimate of the total cost of this provision indicates the total maximum cost could be $3.2 M, or $1.2 M in state funds in the Aged and Disabled Waiver only. However, changing this income standard would potentially allow for an increase in savings associated with home and community-based waiver diversion slots. This provision could be cost neutral, provide program savings, or provide savings that could be the source of funds for waiver expansions as long as the number of waiver slots are controlled. *(See background information below.)*

The bill would require the state to offer home and community-based services on an "on demand" basis to eligible individuals over the age of 65 years. The fiscal impact of this provision will depend upon legislative and administrative actions. If this provision is enacted along with the financial eligibility provisions requiring amendments to the Aged and Disabled waiver including the spousal impoverishment provision and increasing the income standards to 300%, thousands of additional individuals could become eligible for Medicaid waiver services as well as all the State Plan entitlement services. Additional services are estimate to cost in the range of $73.5 M to $192.6 M in state funds. Additional expenditures may result in cost avoidance realized by delaying or avoiding admissions to nursing facilities. However, the requirement to pay for home services would be immediately effective while the potential reduction in nursing home costs may not occur simultaneously or in the same amount as the additional cost. *(See background discussion below.)*

BACKGROUND:

Caretaker Support Program Background: The provisions regarding the Caretaker Support Program establish a program within the Division of Disability, Aging, and Rehabilitative Services (DDARS) similar to the National Family Caregiver Support Program. The national program was added as an amendment to the Older Americans Act in 2000 providing an opportunity for the aging network to develop a service delivery system

to respond to the needs of caretakers. Indiana received a federal grant allocation of $2.3 M that was released in February of 2001. These funds require a 25 % non-federal share that must be provided from state or local sources. The match may be met with cash or in-kind expenditures. The Area Agencies on Aging (AAA) report that the match is provided by the AAAs. The federal requirements for services that must be included in a state program include the following:

(1) information to caregivers about available services;
(2) assistance to caregivers in gaining access to the services;
(3) individual counseling, organization of support groups, and training for caregivers to assist them in making decisions and solving problems related to their caregiving roles;
(4) respite care to enable caregivers to be temporarily relieved from their responsibilities; and
(5) supplemental services, on a limited basis, to complement the care provided by the caregiver.

The federal program has provisions allowing the state agency to use 5% of the total grant or $500,000 to pay for not more than 75% of the cost of administration of the State Plan required for the funding. Five percent of the 2001 state allotment of $2.3 M was $116,580, requiring a state match of $38,860. Since the AAAs received the grant funding, it appears that DDARs was able to establish the state plan and the grant program within the level of administrative resources available. This provision does not require the state to provide additional services, nor does it appropriate funds.

Adult Foster Care Services Background: The bill adds adult foster care to the list of services that are available as a community and home care service option in the state-funded CHOICE program. The CHOICE program is provided to eligible recipients within the level of funding available, so the additional service option would only have a fiscal impact if actions of the General Assembly would provide additional funds specifically related to this option. DDARS has requested an amendment to the Developmentally Disabled Medicaid waiver that adds this service, so administrative actions necessary to define the service and eligible providers may be in process. No services are required to be offered; it is an option that may be made available.

Personal Care Services Summary: This bill would require OMPP to amend the State Medicaid Plan to include personal care services (PCS), an optional benefit, as a Medicaid entitlement service in Indiana. The state may establish utilization control limits on the definition of personal care services, such as limiting the scope and duration of services provided, limiting the categories of eligible individuals who may receive the services, and requiring prior authorization. Further, since the state provides personal care services under the Medicaid Waiver option, the benefit defined for the State Plan may not duplicate the services being made available under the waivers, or the waivers would also need to be amended. (Waiver clients would be entitled to services defined in the State Plan.) Arkansas currently provides personal care services in their State Plan. Based on the relative sizes of the aged, blind, and disabled populations in the two states and considering the average cost of the service as defined and provided in the Arkansas program, the total cost of adding this benefit in Indiana could be $57.5 M, or $21.8 M in state General Funds. Ultimately the cost of this bill would be dependent upon legislative action and administrative implementation of the benefit.

Personal Care Services Background: Personal care services are defined as services provided to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are authorized by a physician or in accordance with a service plan for the individual. Personal care services are provided in a home by a qualified individual who is not a member of the individual's family. PCS may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages that enable them to accomplish tasks they would normally

perform for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing the task for the individual) or cueing the individual to perform the task. The assistance most often involves the performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence; IADLs include more complex activities, such as using a telephone, laundry, grocery shopping, meal preparation, etc.

In 1999, the U.S. General Accounting Office (GAO) reported that 27 states offered personal care services as a benefit under their state plans and 43 states provided personal care under the home and community-based services waiver option. (The waivers offer the ability for states to target services or limit services to defined populations.) States may also offer some limited personal care service as a covered service under the Home Health Care mandatory Medicaid benefit.

OMPP reported that within the Medicaid waivers that offer these services, the total paid for attendant or personal care was $35.9 M in FY 2001 and $48.2 M in FY 2002. The average paid per recipient per year was $12,782 in FY 2001 and $15,088 in FY 2002. The waiver recipients would be expected to be the most in need of the most extensive personal care services; using these per recipient averages would yield an unreasonable cost estimate for the Medicaid population as a whole. Recipients most likely to access services proposed to be offered under the State Plan would be current Medicaid eligibles who might be on a waiver waiting list or who do not meet the institutional level of care required for the waivers but have a medically defined level of need. OMPP has estimated the Medicaid population that would potentially be eligible for personal care services to be 51,032.

The state of Arkansas offers personal care services as an option under its State Medicaid Plan. Arkansas Medicaid imposes a 64-hour benefit limit per month per client for persons age 21 years and older. Additional medically necessary hours may be approved with prior authorization. Clients under the age of 21 receive services on a prior authorization basis only. Arkansas providers are currently paid an hourly rate of $12.36.

In SFY 2002, 16,089 Arkansas recipients used personal care services; total expenditures for the state were $53.4 M. On average, the recipients using personal care benefit used 269 hours (maximum hours billable without prior authorization would be 768). The average expenditure per recipient was $3,321. If Indiana's enrolled population of aged, blind, and disabled individuals is compared to that in Arkansas, approximately 17,300 individuals might be expected to use PCS. The total cost of adding this benefit could be $57.5 M, or $21.8 M in state General Funds.

The Arkansas Medicaid program is different from the Indiana Medicaid program. Examining a single program element has its limitations because of wide disparities in how and to whom state Medicaid programs provide services. Each element of service must be looked at in terms of the state's total long-term care program. Arkansas may experience lower rates of institutionalization than Indiana; the issue of reductions in nursing home expenditures that might be realized by delaying or avoiding institutionalization has not been addressed in this estimate.

Spousal Impoverishment Asset Protection Background: The bill requires the Division to amend the Assisted Living waiver, the Traumatic Brain Injury waiver, and the Aged and Disabled waiver to include asset protection provisions for married couples referred to as spousal impoverishment. Currently, the institutionalization of one spouse, leaving the other to continue to reside in the community, triggers expanded asset protections for the community spouse when determining the Medicaid eligibility of the institutionalized spouse. The community spouse is allowed to keep up to about $89,000 in assets; more than would otherwise

be permitted under the Medicaid rules. (Couples who would prefer to receive services in their own home are currently allowed to keep assets totaling $2,250.) This bill would allow the application of the same spousal impoverishment rules for Medicaid eligibility for in-home waiver services as are applicable for institutional care. In November 2002, DDARS submitted a request to amend the Aged and Disabled waiver to include the spousal impoverishment provisions to the Centers for Medicare and Medicaid Services (CMS). This amendment request is still awaiting CMS approval. The bill would require that DDARS request similar amendments for the Traumatic Brain Injury waiver and the Assisted Living waiver. If the level of funded waiver slots is controlled, this provision would have a minor administrative impact that should be absorbable within the current level of resources available to DDARS. An additional effect of this provision would be to increase the number of individuals eligible for Medicaid waiver in-home services; increasing the waiting list for services. Currently, DDARS reports 493 individuals on the waiting list for services.

300% of the SSI-Level Income Eligibility Standards Increase Background: Similar to the spousal impoverishment protection issue, the monthly income eligibility standard available for home-based waiver services is much lower than the standard available for persons who choose to be admitted to a nursing facility. Under the Medicaid Aged and Disabled waiver, an eligible individual may have no more than the monthly Supplemental Security Income (SSI) amount of $545. This means that if the individual's income exceeds the $545 in any month, the individual must "spend down" the income before they qualify for services that month. In contrast, the same individual can be eligible for nursing home care by paying all of their income, up to $1,635 (300% of the SSI level) less $52 allowed for a personal needs allowance, to the nursing facility. Raising the waiver income eligibility standard to the same 300% SSI level as is available for nursing home care would allow individuals to remain in their homes, maintain more income, and receive services that are generally less costly than those that would be incurred in a nursing facility. A preliminary fiscal estimate of the total cost of this provision indicates the total maximum cost could be $3.2 M, or $1.2 M in state funds in the Aged and Disabled waiver only. The fiscal impact is associated with the elimination of the "spend down" requirement for existing waiver-eligible individuals. The fiscal impact attributable to the Traumatic Brain Injury waiver and the Assisted Living waiver is not known at this time.

Changing the income eligibility standard would potentially allow for an increase in savings associated with home and community-based waiver diversion slots. OMPP has applied for and been approved to add 1,000 priority waiver slots for individuals who are discharged from a hospital to a nursing facility. OMPP has identified this population as a priority for achieving savings by delaying nursing home admission. Often, frail elderly individuals are discharged from a hospital stay to recuperate in a nursing facility. Once in a facility, OMPP has observed that they tend to stay there. With priority waiver slots and equal financial eligibility standards, this population could be targeted to receive in-home services upon return to the individual's home; potential savings would occur immediately. This provision could be cost neutral, provide program savings, or provide savings that could be redirected to fund additional waiver slots as long as the number of waiver slots are controlled. An additional effect of the bill would be to increase the number of individuals eligible for Medicaid waiver in-home services; increasing the waiting list for services. DDARS reports the current waiting list for the Aged and Disabled waiver to be 493 individuals; there were 5 persons on the Assisted Living waiver waiting, and the Traumatic Brain Injury waiver waiting list had 83 individuals.

Home and Community-Based Services on Demand Background: This bill provides that an individual who is 65 years of age, determined to meet the level of care required to be admitted to a nursing facility and eligible for Medicaid assistance under the State Medicaid Plan shall be permitted to choose home-based services instead of a nursing facility. This provision requires that waiver services be provided on an entitlement basis, thus removing the limits on the number of slots that may be filled which constitute the cost controls of the Medicaid waivers.

Waiver recipients must meet the same medical eligibility criteria necessary to justify admission to a nursing facility (unable to perform 3 or more ADL's). The financial eligibility standards are more liberal for nursing home services than those currently in place for home-based services. Recipients may choose to wait for home-based services that may become available when a Medicaid waiver slot opens, or they may choose to immediately enter a nursing facility. In Indiana, the system incentives currently are weighted towards the institutional options. OMPP reported that in FY 2000, 46,200 Medicaid recipients were served in nursing facilities, while 5,089 received home and community-based services.

The 100% state-funded CHOICE program served about 12,537 individuals in FY 2001. CHOICE financial eligibility standards are set at 350% of SSI, and the medical eligibility criteria are more liberal requiring that an individual be unable to perform 2 or more ADL's. If the changes in Medicaid waiver eligibility required by the bill are implemented, a significant number of CHOICE recipients may become eligible for the Medicaid waiver services and Medicaid State Plan services. In addition, the CHOICE program has a reported waiting list of another 12,977 according to the Division. The Division does not know how many of the CHOICE recipients or individuals on the CHOICE waiting list would qualify for higher Medicaid eligibility standards, but this group may constitute a potentially eligible pool of 25,000 individuals. There currently are 493 qualified individuals waiting for Aged and Disabled waiver slots as well. This group would definitely qualify for open slots.

OMPP reports the total FY 2002 annual Medicaid cost for waiver recipients was $19,880 per recipient; average home-based services per recipient were $7,583 and the annual cost for state plan costs for waiver recipients was $12,297.

If the eligible pool of individuals is as many as 25,500, total additional cost could range between $193.4 M, with a state share of $73.5 M, to $506.9 M, with a state share of $192.6 M. This estimate represents a very crude estimate of a complicated policy issue. It does not include a variety of factors that would impact the range of the estimate, such as existing state plan costs of persons who may already be dually eligible with spend down amounts. More importantly, the cost estimate does not attempt to include cost avoidance achieved by delaying or eliminating the need for nursing home care. The Governor's Commission on Home and Community-Based Services and OMPP are engaged in a detailed examination of the issues regarding the equalization of the financial incentives for long-term care services offered under the Medicaid program. A comprehensive fiscal analysis is targeted to be completed by the end of February 2003.

Expenditures in the Medicaid program are shared, with approximately 62% of program expenditures reimbursed by the federal government and 38% provided by the state.

Explanation of State Revenues: See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Family and Social Services Administration, Office of Medicaid Policy and Planning and the Division of Disability, Aging, and Rehabilitative Services.

Local Agencies Affected: Area Agencies on Aging.

Information Sources: Amy Kruzan, Legislative Liaison for the Family and Social Services Administration, (317)-232-1149; "Adults with Severe Disabilities, Federal and State Approaches for Personal Care and Other Services", U.S. General Accounting Office, May 1999 (GAO/HEHS-99-101); "Understanding Medicaid Home and Community Services: A Primer", U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, May 2000; Administration on Aging Program Instructions, at www.aoa.gov/pi/pi-01-02.html ; Governor's Commission of Home and Community-Based Services, Interim Report, December 23, 2002.

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